

## QUESTIONNAIRE FOR POTENTIAL RESPIRATOR USERS

|                               |      |               |
|-------------------------------|------|---------------|
| NAME <i>(Last, First, MI)</i> | AGE  | DATE OF BIRTH |
| JOB TITLE                     | CODE | PHONE NUMBER  |
| SUPERVISOR                    | CODE | PHONE NUMBER  |

### JOB INFORMATION

*(This section to be completed by employee and supervisor)*

PLEASE DESCRIBE THE OPERATION THAT YOU WILL BE PERFORMING FOR WHICH RESPIRATORY PROTECTION IS BEING REQUESTED.

POTENTIAL STRESSORS *(Check all that apply)*

- |                              |                  |               |                 |
|------------------------------|------------------|---------------|-----------------|
| CHEMICALS*                   | NOISE            | CLIMBING      | ENCLOSED SPACES |
| TEMPERATURES EXCEEDING 77° F | HUMID CONDITIONS | HEAVY LIFTING | OTHER*          |

\*LIST ALL CHEMICALS AND OTHER STRESSORS THAT YOU MAY BE EXPOSED TO:

WORK EFFORT DURING RESPIRATORY USE *(Check all that apply)*

- LIGHT *(Sitting while writing, typing, light assembly, standing while operating a drill press or controlling machines)*
- MODERATE *(Sitting while nailing; driving a truck; standing while drilling, nailing, performing assembly work; walking on a level surface; or pushing a wheelbarrow with a heavy load (about 100 lbs.))*
- HEAVY *(Lifting a heavy load (about 50 lbs.); working on a loading dock; shoveling; standing while bricklaying or chipping; walking up a steep grade; climbing stairs with a heavy load (about 50 lbs.))*

INDICATE HOW OFTEN YOU EXPECT TO WEAR THE RESPIRATOR

- ON A DAILY BASIS                      OCCASIONALLY - BUT MORE THAN ONCE A WEEK                      RARELY - OR FOR EMERGENCY SITUATIONS ONLY
- HOW LONG DO YOU EXPECT TO WEAR THE RESPIRATOR DURING AN AVERAGE WORK DAY? \_\_\_\_\_

LIST ANY OTHER PERSONAL PROTECTIVE EQUIPMENT THAT YOU WILL BE REQUIRED TO WEAR WHILE WEARING THE RESPIRATOR *(e.g., safety glasses, ear muffs, coveralls, etc.)*

**RESPIRATOR INFORMATION**

*(This section to be filled out by RPPM, qualified assistant or industrial hygienist)*

TYPE OF RESPIRATOR TO BE USED

|                                |                               |                        |
|--------------------------------|-------------------------------|------------------------|
| HALF-FACE AIR PURIFYING        | POWERED AIR PURIFYING         |                        |
| FULL-FACE AIR PURIFYING        | TIGHT FITTING                 | OTHER <i>(Explain)</i> |
| SCBA, CLOSED CIRCUIT           | HOODED                        |                        |
| SCBA, OPEN CIRCUIT             | SUPPLIED AIR, CONTINUOUS FLOW |                        |
| DISPOSABLE FILTERING FACEPIECE | TIGHT FITTING                 |                        |
|                                | HOODED                        |                        |

TYPE OF CARTRIDGES TO BE USED

|              |                     |           |             |
|--------------|---------------------|-----------|-------------|
| HEPA FILTERS | CHEMICAL CARTRIDGES | CANISTERS | OTHER _____ |
|--------------|---------------------|-----------|-------------|

DESCRIBE ANY OTHER FACTORS RELATING TO THE EMPLOYEE'S PHYSICAL CONDITION, WORK REQUIREMENTS AND RESPIRATORY REQUIREMENTS THAT MAY AFFECT HIS/HER ABILITY TO WEAR RESPIRATORY PROTECTION

**WRITTEN MEDICAL EVALUATION**

*(This section to be completed by health care professional)*

|  |                                       |
|--|---------------------------------------|
| NO RESTRICTIONS ON THE RESPIRATORS CHECKED ABOVE | RESPIRATOR USE WITH SOME RESTRICTIONS |
| NO RESPIRATOR USE ALLOWED                        | ALTERNATE RESPIRATOR RECOMMENDED      |

COMMENTS/RESTRICTIONS

ROUTINE FOLLOW-UP MEDICAL EVALUATION REQUIRED

|       |       |      |   |
|-------|-------|------|---|
| 5 YRS | 2 YRS | 1 YR | DUE TO MEDICAL FINDINGS RETURN ON _____ |
|-------|-------|------|---|

**Employee has been given a copy of this recommendation.**

|   |      |
|---|------|
| SIGNATURE <i>(Health Care Professional)</i> | DATE |
| SIGNATURE <i>(Employee)</i>                 | DATE |
| SIGNATURE <i>(Employee's Supervisor)</i>    | DATE |
| SIGNATURE <i>(RPPM)</i>                     | DATE |

**PRIVACY ACT STATEMENT**

The Privacy Act of 1974 (P.L. 93-579) requires that federal agencies inform individuals about certain facts they are requested to provide for inclusion into government records. These records, as appropriate, may be furnished to agencies of the Federal, State, or local government for legal, regulatory or administrative purposes. Disclosure of the requested information is voluntary, however, if not provided, acceptance of the submitted record may be denied.